

“When I am out with her (befriender) I feel so good mentally and all my physical pains go unnoticed.”
Social Prescribing in Bexley: Pilot Evaluation Report

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Mind in Bexley

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Executive Summary

Social prescribing is becoming recognised as an important means of harnessing the resources of the voluntary and community sector to improve the health and wellbeing of the public. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. While there is no widely agreed definition of social prescribing, or 'community referrals', reports on social prescribing include an extensive range of prescribed interventions and activities.

The paper '*A Call to Action*' by NHS England highlights social prescribing as a crucial means of empowering the public, enabling greater self-management of health and providing for people's non-clinical needs in a timely way. The aim being to promote integrated health and social care, partnered with the voluntary and community sector. There is however little in the way of supporting evidence of effect to inform the commissioning of a social prescribing programme. Evidence on the cost effectiveness of social prescribing schemes is also lacking. The aim of this research was to evaluate the benefits and limitations of a social prescribing pilot which took place in the Clocktower locality (London Borough of Bexley) over a 24-month period and this work forms the main body of the study. The evaluation primarily covers individuals who accessed and fully engaged in the first eight months.

The pilot which started in April 2015 was hosted by Mind in Bexley and focuses on nine GP practices covering a population of approximately 80,000. The evaluation was thorough and comprehensive incorporating both quantitative and qualitative analysis. Quantitative data analysis and draft findings were undertaken by the School of Public Health, Midwifery and Social work at Christchurch University. The quantitative approach included an analysis of the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) in addition to data on the number of primary care and secondary appointments including hospital admission data for those who participated in the scheme.

The qualitative aspect of the evaluation involved in-depth interviews with participants. Although measuring the impact of the project on the wellbeing of participants is challenging the use of both qualitative and quantitative analysis was adopted to ensure the evaluation in terms of measurable outcomes was as rigorous as possible. The information gathered and subsequent report reflects this dual approach and therefore aims to provide a comprehensive evaluation of the project.

Analysis is based on a small number (n=81) of individuals, the limitations of such a small scale study are recognised and discussed, as a result this study does not attempt to claim representativeness or endeavour to generalise from the findings. This small-scale study will therefore attempt to contribute to the limited research on Social Prescribing in London.

The findings from this pilot evaluation suggests that social prescribing could reduce the burden on the healthcare system by decreasing A&E attendances, reducing the number of non-elective hospital admissions, and reducing the average length of stay in hospital. Social prescribing may also have a positive impact on the London Ambulance Service, by reducing ambulance calls. The initiative has also achieved many qualitative outcomes. The project staff have ensured that the measurement of successful outcomes prioritises a focus on the personal, social and emotional achievements gained from individuals accessing the scheme. This is an important focus as the emphasis of the relationships developed within this scheme is a holistic approach rather than a focus of specific 'hard' goals. In many cases 'moving forward' is not measured by hard indicators such as finding employment or an educational/training course, but by evidence of greater

confidence or self-esteem or reducing isolation. The interview data suggests that social prescribing had a beneficial effect on quality of life, wellbeing and social capital of participants. The practical relevance of this study is also significant. All those responsible for planning, delivering and monitoring local primary care and social care services need to improve services for an increasing vulnerable and elderly population, users experiencing mental illness and distress, and relatives and carers including those from Black and Minority Ethnic (BME) communities (Department of Health 2016). It is hoped that this small study could be a first step towards exploring specific initiatives and investing in cost effective initiatives in the community which enhance the Bexley communities' ability and capacity in dealing with, and supporting, complex wellbeing and aged related issues.

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Introduction

The UK is struggling to provide health and social care at an affordable cost. Population growth, long life expectancy for some, increasing expensive technology, and rising patient expectations are widely expected to make this problem worse. In addition, continuing to medicalise society's problems is unsustainable (Branding, 2008). It is acknowledged that within primary care around 20% of all consultations and 50% of consecutive attendances concerns some form of mental health problem, predominantly depression and anxiety (Kessier, Lloyd and Lewis, 1999, Citizens Advice, 2016). According to the Citizens Advice (2016) this represents more than 5% of the NHS England budget for general practice and equivalent to the salaries of 3,750 full time GP's.

A further major challenge to the provision of health and social care for vulnerable elders who reside at home and those with long term conditions is funding and this has become more acute in the light of wider cuts to public and welfare spending. All health and social care services are currently subject to cuts and local authorities including Bexley are under great pressure to reduce their spending in this as in other areas. Glendinning argues that "Long term care in England is widely acknowledged to be seriously under-funded, relative to levels of need. Despite sharing demographic pressures common to all European countries, there has been a continuing political failure to achieve a comprehensive, sustainable and equitable basis for funding social care in England." (2012: 293). To be eligible for support, care needs have to be assessed as increasingly severe despite broader policies that aim to keep people living at home and out of residential care settings.

The vision of the Bexley Clinical Commissioning Group's (CCG) 2016+ plans are for Bexley's residents to stay in better health for longer, with the support of good-quality integrated care. This includes balancing the health economy by providing improved community based integrated care and supporting clients to manage their own health (Bexley CCG, 2016). The public health challenges faced by society today have never been greater (Cramer, 2015). According to Seccombe (2016), chronic disease consumes approximately 70% of the health budget and much of this can be attributed to social-economic factors as discovered in Sir Michael Marmot's (2010) review: 'Fair Society Healthy Lives'. As such, it is crucial to look beyond the traditional medical models of care provision and therefore consider how social prescribing could be beneficial to the ageing population (Seccombe, 2016).

Nationally and indeed locally, steps are being taken to support new approaches to improving health and wellbeing that focus on secondary prevention, personalised care and encouraging individuals to take control of their health. The General Practice Forward View (NHS, 2016) supports increased integration across the wider health and care system, citing social prescribing as a model to enable GPs to access practical, community based support for their patients. The Making Time in General Practice Report (Primary Care Foundation and NHS Alliance, 2015) cites that policy makers are keen to see that more practices offering social support are offered to patients:

"So we need to empower general practice by breaking down the barriers with other sectors, whether social care, community care or mental health providers, so that social prescribing becomes as normal a part of your job as medical prescribing is today." June 19, 2015.

Working in partnership with, and empowering communities to, attend to some of Bexley's residents' more intransigent health issues and challenges seems to be an obvious approach and is in line with stated Government and local policy including joint integrated projects between

health and social care. An aim is to develop collaborative working with community groups and move away from a reactive, disease focused, fragmented model of care towards one that is more proactive, holistic and preventative, in which voluntary sector organisations and residents are encouraged to play a greater role in managing care provision.

What is Social Prescribing?

Whilst there is no one accepted definition of social prescribing, the clearest definition as described by the Centre Forum Mental Health Commission (2014:6) states that social prescribing is '*a mechanism for linking clients with non-medical sources of support within the community.*' Interventions are viewed as strengthening the links between health providers and community, voluntary and local authority services and provide GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing. In these services, there are potential solutions to the wider determinants of mental health for example welfare, culture, leisure and the environment (Nesta, 2013). The literature clearly suggests that social prescribing aims to identify clients within primary care who could benefit from services provided by the voluntary or community sector. It supports secondary prevention, and aims to empower people to take responsibility for their own health and wellbeing (Thomson et al, 2015; Nesta, 2013). According to Evans and colleagues social prescribing provides an innovative approach to health and wellbeing that offers a parallel pathway to conventional medicine and aims to promote social inclusion for people with chronic medical conditions and those from vulnerable, isolated or disadvantaged populations (Evans et al., 2011). Social prescribing is a tool for health professionals to work with clients to address wider social and lifestyle aspects of their health (Nesta, 2013). Those with long term conditions need to adopt healthy behaviours and social prescribing providers can work with the client and agree on a personalised plan of services that could be of benefit to the individual.

There are a variety of reported benefits of social prescribing, from improving mental health outcomes and improving community cohesion, to reducing social exclusion (Friedli & Watson, 2004). The National Institute for Health and Care Excellence (NICE) guidelines endorses community engagement as a strategy for health improvement; this is also based on the substantial amount of evidence of the health benefits of community engagement on clinical care (Nesta, 2013). The evidence suggests that engaging in social interaction and activities in the community makes

Individuals more resilient, having a positive impact on health and wellbeing. Recent government proposals and policy have facilitated a context for developing social prescribing within local communities (Thomson et al, 2015) and according to Cramer (2015) amongst others, evidence shows that social prescribing is an under-used tool and one that can have an extremely positive impact on combating many of the underlying causes of poor health and wellbeing in our society today.

There are few examples of social prescribing models across the UK and there is a need for quality evidence to inform commissioning. Evidence on the cost effectiveness of social prescribing schemes is also lacking. The Rotherham Social Prescribing Pilot is one of the largest funded schemes in the UK. It was based around a core team of a Project Manager and five Voluntary and Community Sector advisors (VCAS's) and received referrals from 28 GP Practices with a total of 808 individuals engaging in the first year. The Rotherham project found strong improvements in wellbeing that supported the borough's Health and Wellbeing Strategy including reduced hospital episodes. Four years after the Rotherham pilot, every GP practice in the region started to use social prescribing and to date 4,000 clients have benefitted. Not only was there a 7% fall in inpatient hospital admissions and a 17% drop in A&E attendances,

the evaluation also concluded that savings of £500,000 were achieved in first three years of the project therefore representing a return of investment of 43p for every £1 spent. The findings have been extremely positive and the scheme has therefore continued. The quality of evidence seems to highlight that there was a high risk of bias in the uncontrolled before and after groups however the qualitative data and case studies were well reported clear improvements in health and wellbeing.

In comparison to the Rotherham Social Prescribing Pilot, a second, much smaller pilot study undertaken in Keynsham, Bath and North East Somerset (B&NES) employed New Route Coordinators (NRC's) that engaged with three GP practices in the region. A total of 90 referrals were received in the first 18 months. The Keynsham B&NES study was based on innovative subjective reflective practice and included tools such as daily completion of diaries by the NRC. The evaluation concluded that those who accessed the scheme demonstrated improvements in wellbeing. The study also identified gaps in local health and social care provision. A more recent social prescribing pilot commenced in 2014 in City and Hackney. The City and Hackney Social Prescribing Pilot included 22 GP practices and had three social prescribing coordinators who made 585 client referrals. The service is delivered by Family Action, a well-established community interest company and was commissioned by City and Hackney CCG. Eighty two community organisations were used in the delivery of the service. Outcomes were measured by a questionnaire at baseline and a follow up after eight months of engagement with the scheme. Although A&E attendance slightly decreased, the pilot found no significant change in outcomes compared to baseline measures and the data indicated that health care resource use remained unaffected. In contrast, qualitative data showed that users had a positive experience and there were some powerful narratives about the impact of social prescribing. Interestingly social prescribing co-ordinators seemed to be well established in primary care however their identity as social prescribers was lost partly because of the variety of terms used to describe them but also because participants saw so many different health professionals that they lost track of who they were seeing.

Social Prescribing in Bexley

Bexley is facing some important health challenges. Between 2001 and 2014, the number of older people (aged 65 years and over) in Bexley has increased by 16.6%. Between 2014 and 2021, this population group is predicted to continue increasing, placing increasing pressures on public services. Life expectancy at the age of 65 years in Bexley is also above the national average for both males and females (Bexley CCG, 2016).

Social prescribing was launched in Bexley on 1st April 2015 in one specific geographical area (Bexley Clocktower) and was jointly funded by the Bexley Clinical Commissioning Group (CCG) and the London Borough of Bexley. The pilot included nine GP surgeries, and was initially aimed at clients who were 65 years and over. After the initial three months, the eligibility criteria was widened to include those aged 18 years and over and also included the opportunity for individuals to self-refer.

The social prescribing pilot in Bexley is based around one social prescribing coordinator, who is employed by, and based at, Mind in Bexley. The co-ordinator provides a mix of formal referring and informal signposting according to individual need. The social prescribing coordinator meets clients at a mutually beneficial location, which includes home visits, GP surgeries, and community locations and has access to a range of voluntary and community services and activities who have signed up to be part of the initiative. Some of these

organisations signed up to the social prescribing pilot, and were included in the project development and used the projects web tool (see below) so that the referral process and outcomes could be monitored. Additional voluntary and community services which had not formally signed up to the programme were identified by the coordinator, and formed the basis of informal signposting, where appropriate.

Following a mid-programme review of the pilot, the coordinator identified a barrier to the service; namely that some clients found it difficult to attend the social prescribing assessments at GP surgeries primarily due to mobility. As a result, home visits and assessments in community locations were included at the assessment stage. This also had the added benefit of being more attractive to those groups who were less keen to attend GP surgeries such as younger clients or those who are carers or have young children. Alongside the point highlighted above, the number of clients declining the service has steadily reduced throughout the pilot. This is because the coordinator offers a call back after three months to those clients who are less keen on social prescribing at time of referral to review their appetite for the scheme and also reassess their needs. Originally, volunteers trained by Bexley Voluntary Service Council (BVSC) would enter GP surgeries to promote the scheme and hand out fliers. This was useful in promoting the project however we found that clients were more focused on seeing their GP than considering Social Prescribing. This however was found to be a good way to recruit carers to the scheme.

Study Design and Data Collection

The Social Prescribing programme was based in the Clocktower locality in the London Borough of Bexley. Bexley has a population of 232,000 and lies to the South East of Greater London, one of those boroughs referred to as 'Outer London'. The gender split is 52% female and 48% male. The most significant increases in population have occurred in the 0-4 year old group and the 85+ age group which have shown rises since 2001 of 14.3% and 26.5% respectively. Bexley has common borders with the London Borough of Bromley to the South, the London Borough of Greenwich to the West and the River Thames is the Northern boundary with the London Borough of Havering and the London Borough of Barking and Dagenham. To the East there is a boundary with the Dartford Borough in Kent. The MINI2K score for Bexley is 0.79, indicating low average mental health needs of the population. At the 2011 census, 80.5% of Bexley residents reported themselves as White British, 5.5% as White Other, 2.2% as Mixed, 7.5% as Asian, 3.3 7% as Black, and 1.0% as being from other ethnic groups. (www.londonboroughofbexley.gov.uk).

Participants in the programme were referred from GP's and Healthcare Practitioners who worked in GP Surgeries or by self-referral. The surgeries who participated were: Albion, Bellegrave, Burstled Wood, Crook Log, Ingleton Avenue Surgery, Welling Medical Practice, Littleheath, Westwood and Bexley Group Practice.

All participants that were referred or self-referred to social prescribing (whether they were a carer or not) must have satisfied two or more of the following criteria

- Aged 18+ years
- Socially isolated – i.e. seeing friends or family less than once a week
- A frequent user of primary care services or A&E
- Struggling to manage a significant life change

- Struggling to manage their health conditions
- **or** a carer for somebody else with a long term condition.

Participants (besides carers) must have had one or more long-term conditions to be eligible for social prescribing.

Patients were not suitable if they had:

- Active suicidal ideas
- A current or lifetime diagnosis of psychosis, personality disorder or organic mental disorder

The Bexley evaluation incorporated qualitative and quantitative data. The use of a variety of sources bolstered the study's internal validity, triangulated the data and provided a more complete picture of Social Prescribing provision for residents in Clocktower, Bexley. The Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) was used at baseline and at six months to measure clients' mental wellbeing. Quantitative measures also included data on GP surgery appointments, hospital data, A&E admissions and data from the London Ambulance Service. Quantitative data were subject to descriptive analysis using Microsoft Excel 2013 and statistical analysis using SPSS Version 22 was undertaken by Christchurch University.

To explore and gain insights into the impact of the scheme on participants, a qualitative inductive research design was employed. Various qualitative methods were used including ethnographic observations, participations in meetings and open-ended, semi structured interviews with participants, which allowed for 'thick description' (Geertz 1973) through the narratives that emerged. For the purposes of this evaluation, the findings reported here are from the interview data with those who fully completed the scheme. Saturation was achieved with forty nine participants. Ethical issues were considered in depth by a small steering group which met bi-monthly and discussed with stakeholders. We note the particular ethical issues arising from research into elders and vulnerable adults and those with complex mental and physical ill health. Great care was taken to ensure that this evaluation was non-obtrusive and supportive. Voluntary participation, and confidentiality were emphasised and researchers made it clear that participants could withdraw at any stage. The purpose of the evaluation was clarified, and informed consent was obtained, from all participants. Pseudonyms have been selected for all participants.

Narrative Analysis

Data analysis of interviews followed the 'Framework' approach (Ritchie and Lewis 2003) a content analysis technique widely used in qualitative research. Each of the transcripts was read and re-read by the authors, following which a coded framework was devised. Thematic categories were applied to each transcript and then 'charted', a process by which key points of each data were summarised and documented on an EXCEL matrix. Thus a set of categories were obtained which described the main themes arising from the interviews.

The findings and discussion section has been merged due to the nature of the findings. The quantitative findings are supported by qualitative and informative research with individual 'voices' narrating stories, expressing opinion, and therefore contributing to the on-going discourse within the field of social prescribing and health and social care research in general. The equitable nature of valuing individual subjective knowledges supports the objective that the findings are incorporated into the discussion and given validity in the debate and analysis.

Demographic profile of the clients referred to social prescribing

At the time of the evaluation, 245 clients have been referred to the social prescribing service in Bexley.¹ The evaluation focusses on approximately a third (n=81) of these participants. These (n=81) were referred in the first eight months of the programme.

An additional 30 (18F and 12M) individuals were referred to the project but declined to take part. Reasons cited included little interest in the scheme, being too unwell, in hospital or in residential care settings. Of the 81 clients who took part in the evaluation, the majority were female (69%). Client's ages ranged from 29 to 93 years at the point of referral (Table 1). Over two thirds (69%) were over 75 years old, the mean age was 77 years and the median 79 years.

Table 1: Age of social prescribing clients

Age range	Frequency	Percentage
25-34	1	1%
35-44	1	1%
46-54	3	4%
55-64	5	6%
65-74	15	19%
75+	56	69%
Total	81	

Source of, and reason for, social prescribing referrals

Table 2 provides an overview of the number of social prescribing referrals by GP surgeries. On average, there were 27 referral per practice, with Westwood making the greatest number (n=64), followed closely by Bellegrave (n=46) and Albion (n=41). GPs at Ingleton made the lowest number of referrals to social prescribing (n=2). This shows the disparity in the level of engagement in social prescribing across the Clocktower (n=9) surgeries.

Table 2: Number of referrals to social prescribing by GP practice

GP practice	Number of referrals
Westwood	64
Bellegrave	46
Albion	41
Little Heath	38
Bexley	19
Welling	14
Crook log	9
Burstead Wood	8
Ingleton	2
Average	27

¹ Figure correct as of 09/01/2017

Table 3 illustrates the reason for referral to social prescribing. Most commonly, clients were referred to social prescribing because they were struggling with a significant life change (63%), struggling with a health condition (54%) and/or due to social isolation (47%).

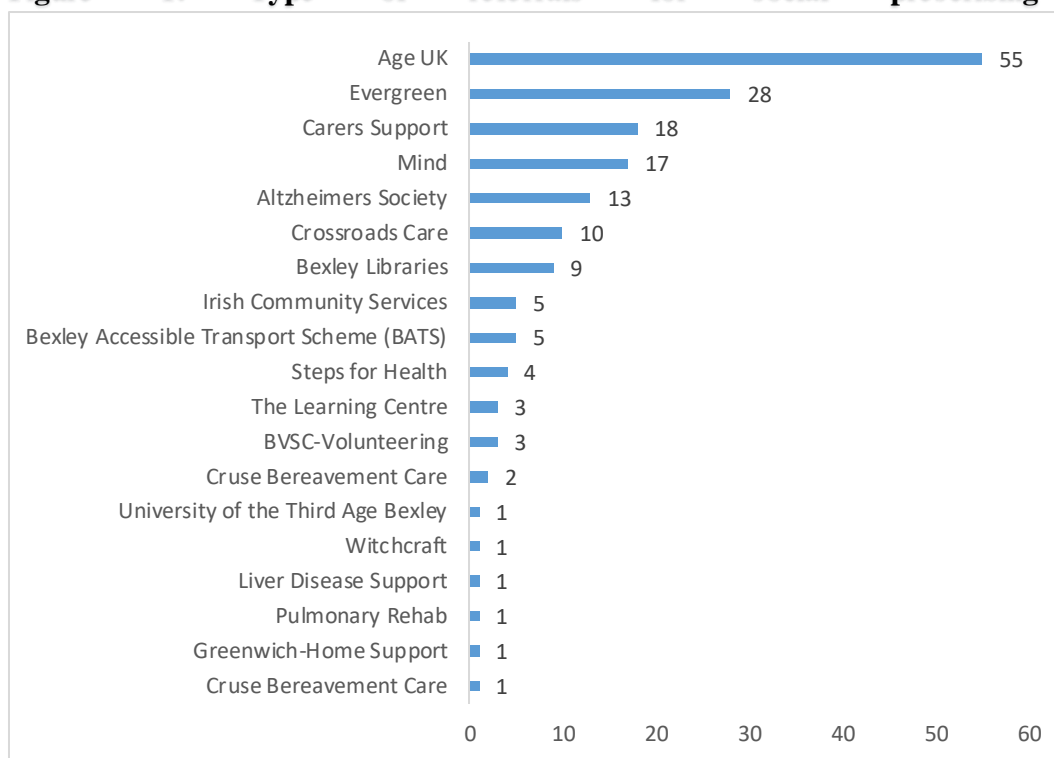
Table 3: Reason for referral to social prescribing

Reason for referral	Percentage
Struggling with significant life change	63%
Struggling with their health conditions	54%
Socially isolated	47%
Frequent attenders of primary care/A&E	31%
Have dementia	21%
Carers	19%
Carers who have long term conditions	12%

Onward referrals

Figure 1 illustrates the details of referrals made by the social prescribing coordinator. There were a total of 170 referrals made to voluntary agencies. This represents an average of 2.2 referrals per individuals. The greatest number of referrals for one client was 7. * Based on the evaluation sample (n=81)

Figure 1: Type of referrals for social prescribing clients*



Almost a third of referrals were made to Age UK (31%), with referrals to their befriending scheme and/or pop in parlours (now called wellbeing centres) most common (both n=14) (Table 4). 15% of referrals were made to Evergreen, with the majority referred to their Trusted Tradesman programme (n=9) and Home Support initiative (n=7). Ten per cent of referrals were made to Mind with the majority referred to their CCG funded Increasing Access to Psychological Therapies (IAPT) service (n=8) and additional ten per cent were made to Carers Support, with seven individuals accessing support for Financial Advice.

Table 4: Breakdown of referrals by social prescribing by organisation

Referral provider	Frequency
Age UK- Men in Sheds	5
Age UK-Befriending	14
Age UK-Community Support Services	6
Age UK-Day Centres	9
Age UK-Home Support	2
Age UK-Memory Café	1
Age UK-Pop in Parlours	14
Age UK-Trusted Tradesmen	0
Age UK-Volunteering	4
Alzheimer's Society-3 weekly activity Group	1

Alzheimer's Society-Dementia Society	2
Alzheimer's Society-Singing for the Brain	2
Alzheimer's Society-Carer Info Programme	1
Alzheimer's Society-Dementia Support	7
Bexley Accessible Transport Scheme (BATS)	5
Bexley Libraries-Activities	1
Bexley Libraries-Games Club	2
Bexley Libraries-IT Buddies	5
Bexley Library-reading Group	1
BVSC-Volunteering	3
Careers Support -Care Navigation	3
Careers Support-Befriending	1
Careers Support-Careers Wellbeing Hub	1
Careers Support-Day Centre	1
Careers Support-Emotional Support	1
Careers Support-Financial Advice	7
Careers Support-Respite	4
Careers Support-Support Group	0
Crossroads Care-Befriending	4
Crossroads Care-Memory Cafe	2
Crossroads Care-Monthly Tea Groups	1
Crossroads Care-Respite	3
Evergreen Befriending	7
Evergreen Care - General	0
Evergreen Care-Home Support	7
Evergreen Care-Trusted Tradesmen	9
Evergreen Volunteering	2
Evergreen-Clean Team	2
Evergreen-Knitters	1
Irish Community Services - Out & About Befriending	2
Irish Community Services-Financial Advice	1

Irish Community Services-Lunch Clubs	2
Mind Nexus	2
Mind-Health Trainer	3
Mind-IAPT	8
Mind-Mindfulness	1
Mind-Peer Support	1
Mind-Recovery College	1
Mind-Recovery College-Art Group	1
Steps for health	4
The Learning Centre Bexley-Courses	3
Total	170

In terms of signposting, most were made for bereavement counselling at Cruse Bereavement Care (n=3) (Table 5).

Table 5: Breakdown of signposting's by social prescribing by organisation

Provider	Frequency
Bereavement Counselling-Cruse	3
Greenwich-Home Support	1
Pulmonary Rehab	1
Liver Disease Support	1
University of the Third Age	1
Bexley Walks	1
Total	8

Findings: Impact of social prescribing

Links to the Voluntary Sector

CCGs and Local Authorities are required to demonstrate that they have a range of mechanisms in place to engage with patients, carers and their communities, and to work in partnership with voluntary/charitable sector groups. Social prescription requires a fundamental change in the way health professionals talk to their patients and for them to consider people's broader social and psychological needs. Care planning can help to provide a framework for having a different type of consultation. In busy GP practices, it is not always possible to keep up to date with the range of services that the local voluntary and community sector can offer and CCGs will not have the capacity to respond to approaches from individual voluntary-sector organisations. Social prescribing in Bexley offers a model for effective partnership working, with one organisation (Mind Bexley) taking a lead role in managing the assessment and referral process.

As a matter of course, social prescribing brings together a wide variety of different organisations that need to work in partnership to achieve the health and wellbeing outcomes they're aiming for. This extends beyond local voluntary sector infrastructure and the local authority and includes others whose work is relevant to public health: CCGs, individual GPs, colleges as well as community groups and smaller local charities. Unlocking the potential of social prescribing is dependent on meaningful and productive relationships which bring together old and new partners. In Bexley, the social prescribing coordinator has oversight of various community programmes designed to support mental health, social isolation, leisure, learning, welfare, environment and employment. Referrals have been made to an array of organisations including Age UK Bexley, Mind in Bexley, Carer Support, Alzheimer's Society Bexley, Crossroads Care Southeast London, Bexley Mencap, Bexley Voluntary Service Council, the Learning Centre Bexley, London Borough of Bexley Sports and Development, London Borough of Bexley Libraries, Diabetes UK, Bexley Deaf Centre, Evergreen Care, Irish Community Services and Bexley Accessible Transport Scheme.

The voluntary sector is integral to working in partnership with GPs and the Local Authority to ensure the wider good health and wellbeing of the Bexley community. The sector tends to be more connected with marginalized groups and communities and have the expertise to tackle the wider social and economic factors which impact on health. It was suggested, and anecdotally supported by other agencies and clients, that hosting the pilot in a non-health setting (Mind) reduced the potential for both a lengthy referral process and the possible stigma attached to receiving such support:

“Having the project based in the local community is the way forward also Mind and Age UK have established working relationships with each other and with lots of services in the community. We have good links in the community so it's easy for residents to access the project. They feel safe and there is no stigma attached” (Age UK, Bexleyheath, Pop in Parlour)

In addition, Mind in Bexley were perhaps able to provide a more flexible service including home visits, which may not have been achievable within statutory NHS structures and referral procedures. This may have been more appealing to some participants with regards to stigma, primarily because it was within a community setting. This meant that participants did not become part of the mental health “system”, or become unnecessarily identified with it, while benefiting from the service provided.

“It was quick and easy to get referred to the programme. I didn't have to wait long and what I also liked was that I didn't have to use medical services. I didn't have to worry about people walking past and seeing me around.”

We have contacted all surgeries involved in the scheme to comment on the process and engagement with the voluntary sector however we received no feedback. This may have been due to time constraints and busy practices.

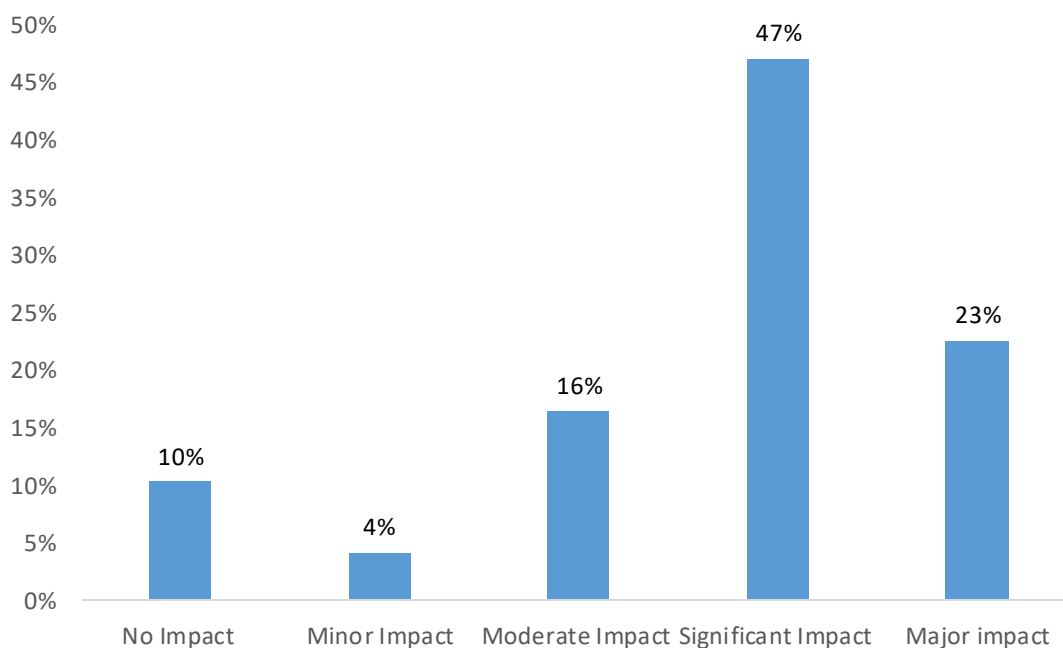
The long term aim of the Bexley social prescribing project is to improve mental health and quality of life and/or to ameliorate symptoms, measured through, for example, improved Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) scores, This measure is used to

measure key elements of mental health and wellbeing. Analysis of the quantitative data and interviews undertaken suggests that social prescribing in Bexley is viewed very positively by those who have engaged with the scheme (Figure 2). Over two thirds of clients reported that social prescribing had a significant (47%) or major (23%) impact on their quality of life. Those who reported a significant or major impact on their quality of life also had fewer A&E attendances, fewer non-elective admissions and had reduced hospital stay six months after their social prescribing referral.

A 51-year-old woman was referred by her GP because she was struggling with a recent family bereavement. Social prescribing referred her to an emotional supportive programme which according to the participant helped her to ‘turn her life around’.

“I’ve had some very dark moments. The bereavement counselling really helped me and it’s helped me keep my anxiousness at bay. Although I still have some bad days I feel I am now able to adjust and start trying to rebuild my life again.”

Figure 2: Perceived impact of social prescribing on client quality of life



As highlighted above the impact of social prescribing on client wellbeing in Bexley was measured by mixed methods including using the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS). WEMWBS is a measure of mental well-being focusing entirely on positive aspects of mental health. As a short and psychometrically robust scale, it offers promise as a tool for monitoring mental well-being at a population level. Of those who responded, (100%) fully completed WEMWBS. While it is impossible to be precise about how much change in WEMWBS is considered ‘meaningful’, best estimates range from 3 to 8 WEMWBS points difference between ‘before’ and ‘after’ time points. So if a participant’s score increased by three to eight WEMWBS points during the project, WEMWBS would be

demonstrating that mental wellbeing meaningfully improved over the course of the project. On average, client’s mental wellbeing scores increased by 4 points after social prescribing (Table 6). The WEMWBS describes this as a meaningful increase in wellbeing.

Table 6: Mean WEMWBS scores before and after social prescribing

6 months before referral to social prescribing	6 months before to social prescribing	6 months after referral to social prescribing	Difference
43.45		47.31	3.86

The following data explores the impact of social prescribing on A&E attendance, non-elective admissions and appointments at GP surgeries.

Emergency admissions and emergency attendance

A further impact of social prescribing can also be demonstrated by comparing A&E data for participants before and after social prescribing. Out of the sample of 81 clients reviewed for this evaluation, 26 (32%) had attended A&E in the six months either before or/and after their social prescribing referral. Table 7 illustrates that the average number of A&E attendances per client decreased after social prescribing (2.5 compared to 1.4). This represents a decline of 43% in A&E attendance after social prescribing compared to the 6 months before social prescribing.

Table 7: Average number of attendances per client to A and E before referral and after social prescribing referral*

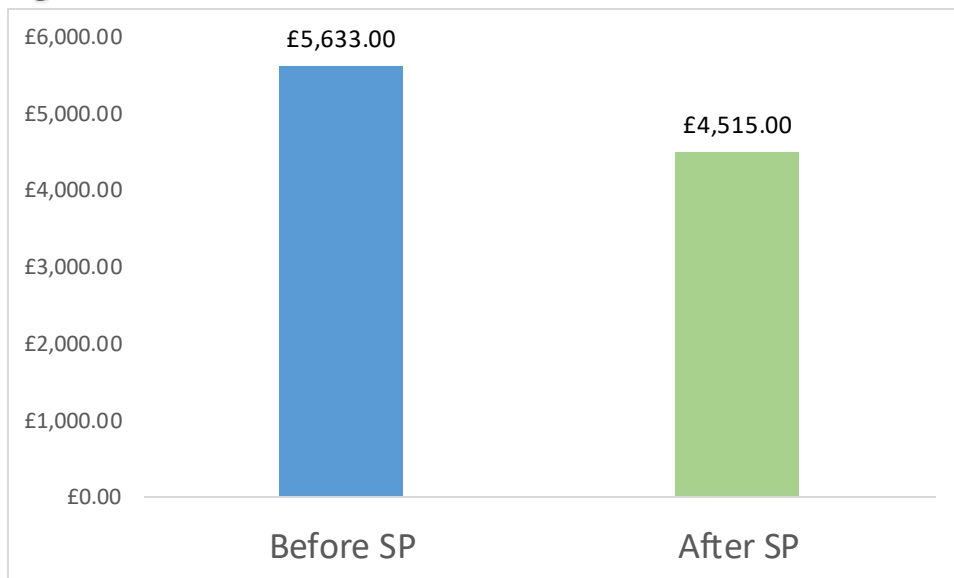
	6 months before to referral to social prescribing service	6 months after referral to social prescribing service
Average number of emergency attendance per client at A and E	2.5	1.4

* Excluding those who are now deceased or those in residential care homes

Figure 3 highlights the total cost of A&E visits before and after social prescribing. According to costs supplied by Bexley CCG, the total cost of A&E attendances reduced by £1,118 6 months after social prescribing. The average cost of an A&E attendance reduced by £30.35 per client, from £331 to £301.2

² Average cost is based on those who attended A&E, not whole sample of 81 patients.

Figure 3: Total cost of A&E attendances 6 months before and after social prescribing

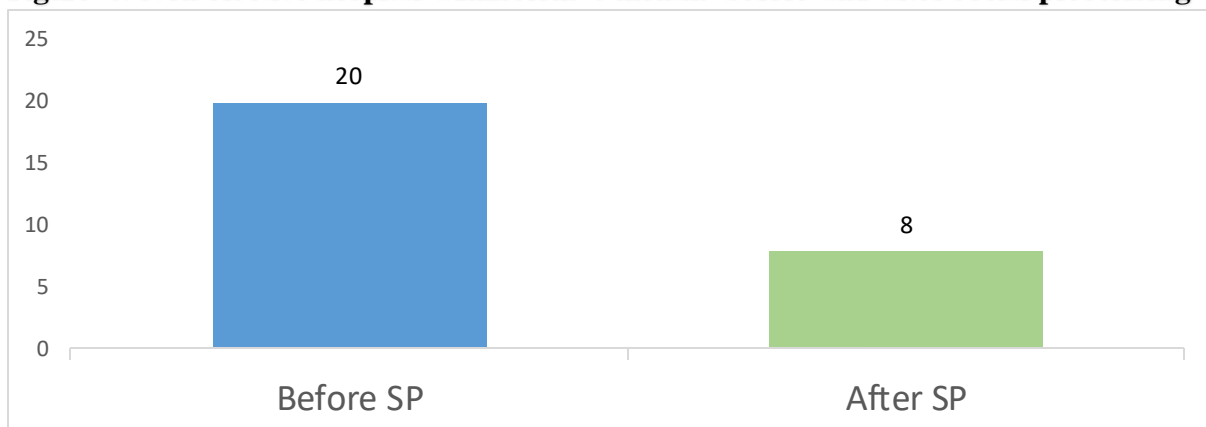


* Excluding deceased clients and those in care homes

Non-elective admissions

Of those who participated in this evaluation, 16 clients had non-elective hospital admissions six months before and/or after social prescribing. There were a total of 28 admissions, 20 in the six months before social prescribing and 8 in the six months after (Figure 4). This demonstrates a 60% reduction following social prescribing. According to data supplied by Bexley CCG, the total cost of non-elective admissions also reduced after social prescribing, from £39,576 to £16,968.

Figure 4: Non-elective hospital admissions 6 months before and after social prescribing*



* Excluding those who are now deceased and those in residential care homes

Length of stay in hospital

Of the 81 clients who participated in this evaluation, 15 (19%) were admitted to hospital either before and/or after social prescribing. The average length of stay was 7 days longer in the 6

months before the social prescribing referral (an average of 37 days) compared to those admitted after engagement with social prescribing (30 days) (Figure 5).

Figure 5: Average length of stay in hospital (in days): Comparing 6 months before and 6 months after social prescribing*

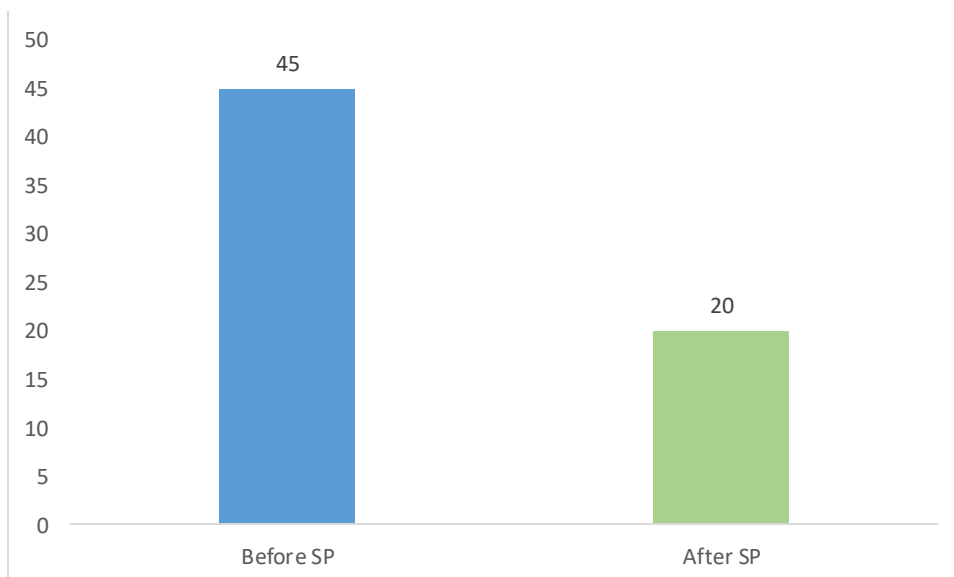


* Excluding those who are now deceased and those in care homes

Impact on the London Ambulance Service

Of the 81 clients, almost a quarter (n=18) had used the London Ambulance service in the six months before and/or after their social prescribing referral (22%). 47 calls were made in the six months before social prescribing (an average of 2.5 calls per person), whilst 20 calls were made in the six months after the referral (Figure 6). This represents a reduction of 56%.

Figure 6: Calls made to the London Ambulance Service: Comparing 6 months before and 6 months after social prescribing*



* Excluding those who are now deceased and those in care homes

These findings were viewed very positively by a senior member of the London Ambulance Service who felt that social prescribing “aligns well with the management of frequent callers:

They felt that the findings were “notable and the efficiencies would be relatively easy to estimate in terms of time and money...and be well appreciated by wider health and social care audiences, (although) the true value of social prescribing can be found in the qualitative data which we rarely obtain or analyse within healthcare.”

Impact on GP surgeries

On average, appointments at GP surgeries increased after social prescribing (Table 8). This is based on data from nine GP surgeries in Bexley. It is important to note that many of the social prescribing clients are elderly and have long term chronic and complex health conditions (e.g. dementia, diabetes, COPD, hypertension) that require regular consultation with primary healthcare professionals in GP surgeries. As such, it is unlikely that social prescribing would be able to have an impact on their requirements for primary care. These findings are consistent with data from other Social Prescribing evaluations.

Table 8: Primary care appointments at GP surgeries before and after social prescribing*

6 months before social prescribing referral	6 months after social prescribing referral	Difference
5.1	5.5	+0.4

* Deceased clients, those living in residential care homes/hospices and those who moved surgery were excluded from this analysis.

It is important to note that many GP surgeries were not able to differentiate between appointments with GPs, home visits, nurse appointments and appointments with healthcare assistants (HCAs). One surgery, Bellegrave, was however able to differentiate between type of primary care professional. In this surgery (Table 9), the average number of GP appointments actually decreased from 4.4 to 3.9 after social prescribing. Average number of appointments with the nurse also decreased (2.0 to 1.6), whereas appointments with HCAs increased from 1.6 to 2.0 after social prescribing.

Table 9: Bellegrave primary care appointments at GP surgeries by professional type before and after social prescribing*

Change in number of average appointments before and after social prescribing		
GP	Nurse	Healthcare assistant
-0.5	-0.4	+0.4

* Deceased clients, those living in Residential care homes/hospices and those who moved surgery were excluded from this analysis. Based on 14 clients.

Being unable to break appointments down by primary care professional is a limitation of this data. As illustrated by Bellegrave surgery, despite the average number of primary care appointments remaining the same (before versus after social prescribing), there was a decrease

in appointments with GPs and nurses, which had been balanced by an increase with HCAs. This finding illustrates the potential public health savings that could be made as a result of social prescribing.

Impact on health beyond primary care

These figures are not illustrative of the full impact of social prescribing on the wellbeing of those who participated. The Bexley service focused on an in depth assessment of individual social, emotional and practical support needs. For example, the social prescribing coordinator has been able to identify additional medical or safeguarding issues as a result of the social prescribing referral and as such, has been able to raise and act on these issues with primary care professionals. This has strengthened working relationships with GPs and adheres to a holistic model of health which acknowledges that social and non-medical issues can have an effect on an individual's health. This co-ordinated approach worked well and is a model for effective partnership working.

In one example, the social prescribing coordinator conducted a home visit with an elderly lady with diverticulitis who had also had part of her bowel removed. She was living in a shed in the garden of a B&B in Welling and had to enter the main house to use the toilet and wash room facilities. Her condition meant she needed to access a toilet frequently and as a result of having no immediate access to bathroom facilities, the individual had stopped eating. The social prescriber informed the GP and also referred her to an appropriate organisation for support with her housing needs. She is now living in suitable accommodation that meets her physical health needs. A safeguarding referral was also raised. In another example, the social prescriber did a home visit to an elderly lady who has dementia. This was a pre-booked appointment. Not only did the lady forget the appointment was taking place, but she was not able to unlock the door herself as a result of her dementia. The social prescriber was able to engage with the GP surgery, who were able to get in make contact with a family member and a review was undertaken of the client's needs.

The ability of the social prescribing coordinator to identify additional needs, and raise these with relevant healthcare and support professionals provides a valuable service both for the individual client and the health and social care services as a whole. It is important to note that identification of these additional requirements may actually result in increased costs to health and social care services immediately after a social prescribing referral. From the evaluation sample, there are a number of examples of clients who later went onto to access additional support and services from primary care (e.g. GP surgery appointments, A&E requirements and/or hospital admissions) and social care. This is partly attributed to the issues raised by the social prescribing coordinator.

Thematic Analysis - Reporting the individual subjective experience

One of the benefits of this evaluation was asking those who participated to report their own subjective perception of their own wellbeing. This allows for meaning to evolve from the clients themselves as they are given agency and control, allowing them to self-define their own feelings. This means the evaluation can be dynamic and credible. There were three key emerging themes from the interview data.

Slipping through the net

“It’s all very new to me dealing with this sort of thing as I’ve never really had to before so I don’t even know where to start!”

Social prescribing provides individuals with opportunities to access an array of social, voluntary and/or community activities that they were previously unaware of. The coordinator explores individual health and social needs, and then refers them to appropriate services according to their individual requirements. The traditional service-led approach has often meant that people have not received the right support at the right time and have been unable to shape the kind of support they need. The Social Prescribing model is about giving people much more choice and control over their lives. Through working in partnership with an array of organisations. Social Prescribing in Bexley aims to address the needs and aspirations of individuals and carers to ensure everyone referred to the scheme has access to the right information, advice and support. It means ensuring that people have access to services such as leisure and befriending, housing, support, health and volunteering opportunities.

There is an array of research that indicates that involvement in social and community based activities where people interact and develop relationships reduces feelings of loneliness and provide a sense of belonging and purpose (Bagwell et al., 1998; Zambo, 2010). Although many of us experience loneliness at one time or another, it is often overlooked or dismissed. Loneliness might accompany depression or another psychological illness, but it has its own set of characteristics that have specific implications for our mental, physical and societal health (Cornwell and Waite, 2009). Studies undertaken on reducing social isolation highlights several groups at increased risk of this issue, including new mothers, children and young people experiencing bullying, people with long-term conditions and disability, unemployed adults, carers and elders. Many of the risk factors associated with social isolation are more prevalent among socially disadvantaged groups and accumulate throughout life; for example, social isolation in childhood is associated with isolation in adolescence and adulthood. The process of ageing sees many individuals progressively adapting to changed personal circumstances such as bereavement and/or relocation.

Many participants spoke about “loneliness”, “social isolation” and “living alone” and were used interchangeably. Although they are three distinct (but linked) concepts, individuals frequently indicated that they rarely participative in activities and individuals had minimal contact with others and/or a generally low level of involvement in community life in Bexley. As a result, individuals spoke about ‘slipping through the net’ which had negatively affected both physical and mental health, particularly among older adults.

“Well I must have been slipping though the net you know for the last 25 years.,.,,”

“I’m so glad you are doing this.....it would have been so easy for me to have just continued to sit in the chair at home and not go out. I’ve been like this since she passed away and now meeting people in the same boat as me in the café has really helped me”

Factors contributing to exclusion include being aged 60 or over, being female and living alone with no living children, suffering poor physical/mental health (especially depression), carers and lacking access to public transport.

“I feel like I’m stuck on a desert island. I never go out, don’t socialise...I only went out once last year and that’s only because I was a bridesmaid. I’m stuck in doors...I’m always having to look after mum and I can’t leave her. It’s very difficult you know. I can’t go on like this”

Social prescribing as it relates to social networks and support

Research demonstrates that positive social relationships and networks can promote health for people at any age through, for example:

- providing individuals with a sense of belonging and identity
- sharing knowledge on how to access health and other public information and services
- influencing behaviour, for example through support from family or friends to reduce alcohol intake, or to access health care when needed
- Providing social support to cope with challenges such as pressures at work, or life changes such as becoming a new parent or dealing with the caring roll.

The social prescribing scheme in Bexley helps to reduce social isolation by engaging clients in social community activities and events. In this way, it supports increased social cohesion and benefits individuals who are able to engage with others with similar profiles and shared interests.

“The Dementia café is brilliant. All the girls around there they all know me..... they make everybody welcome.”

An individual who was referred to a befriending service via Social Prescribing reported:

‘I look forward to going out. She (befriender) has made a hell of a difference and I like it when she can give me a specific day that she is coming so as I can look forward to it. When I am out with her I feel so good mentally and all my physical pains go unnoticed.’

Encouraging clients to engage in community activities promotes social capital, which is a beneficial resource both for the individual and society. One of the benefits of increased social capital is that it can reduce social inequality by focusing on social relations and resources, helping individuals to achieve things they wouldn’t on their own (Putman, 2000). In this way, social networks create collective value and provide reciprocal benefits for individuals within

that society (Castiglione D et al 2008). Support groups are an example of social capital and its benefit to groups and individuals in the social prescribing context. Individual wellbeing is strongly associated with community inclusion

“I now go to Bingo in the Pop in Parlour on a Tuesday and I’ve met loads of lovely people who I have so much in common with. We talk, play some bingo and then go out for tea and cake afterwards. We look out for each now and I feel I can talk with them. We also have a laugh which is great I hadn’t laughed for years Jacqui you know..... ”

It is the older and/or immobile social prescribing clients may struggle to access many of the current services provided by the voluntary and community sector in Bexley. Befriending is often a good option for these individuals.

“Thanks to you I’m now linked up with the Irish Community services and I go to the lunch clubs a few times a week. We also reminisce over life back home which is a great crac They put me in contact with a nice volunteer (Befriender) who takes me shopping and comes with me to my hospital appointments.”

Social prescribing as it relates to quality of life

Some individuals were referred to counselling and recovery services in order to improve mental wellbeing. Participants talked favorably about the counselling provision and self-help CBT intervention at Mind. When asked how they had benefited from the scheme, Improved confidence and self-esteem, positive thinking, and better coping strategies were most frequently mentioned:

“I liked it. It’s made me more of a positive person. I’d like to say I’m not looking at everything so negatively now”.

One participant described similar issues:

“It made me confident, even my friends said I speak out more now and I’m able to rationalise things better than before”.

Participants also reported that social prescribing had a positive impact on their own relationships, with others including partners, spouses and loved ones. A carer on the programme reported that she and her husband have been attending a memory café hosted by the Alzheimer’s Society. She reported that her husband has improved and is now far more receptive, his demeanor has improved and his memory is better. As a result, they now do more activities outside of the house.

“I now know how to deal with him so feel better.”

An elderly couple were both social prescribing clients; one had dementia and the other had mobility issues. They were referred to the Alzheimer’s Society ‘singing for the brain sessions’.

Engagement with Alzheimer's Society has reduced the conflict in their relationship and both are much calmer and able to go out and complete activities together. The daughter said

“this is the first time they've been able to do this in five months. I feel it is because of how positive and calm Mum was after the singing sessions. I am so grateful for the support they've had.”

Social prescribing as also made some clients feel stronger, more resilience and increased their feeling of purpose.

“I think Social Prescribing lifted me out my cloud and got me focused. I can start to look forward.”

Many of the clients in the social prescribing pilot had multi-faceted and complex medical, physical, mobility and psychological needs. Alongside this, the majority are elderly, with many living alone and/or without much social interaction. Some clients were also housebound, living alone at the onset of dementia.

Case study: An 86-year-old woman who was referred to social prescribing after being in hospital. She has dementia and has recently moved into her daughter's home. Her mental condition is worse since leaving hospital. She also has lymphedema and a foot injury. She also has a chronic cough and difficulty passing urine. Her anxiety is worsening. She hallucinates and is at risk of falling. She wakes up often in the night. Her daughter is exhausted, and she has had to reduce her full time job to part time. She hasn't been at work for several weeks because her mother cannot be left alone. Both are now clients of social prescribing, and have both had several referrals and action plans.

Caring about carers

Research undertaken on Mental Health Carers by Mind in Bexley in 2013 found that this group is often invisible, with many older carers providing long hours of vital care and support while their own health and wellbeing deteriorates, resulting in poor physical and mental health, financial strain, and breakdown in their ability to carry on in the caring role. With an ageing population and increasing demand on health and social care services, supporting carers including older carers better is a key way of keeping people at home, independent and healthy and was as significant aspect of Social Prescribing.

The Bexley Social prescribing initiative supported carers by referring to agencies

- Who provide specialist advice on the caring role about expanding their social support networks and contacts.
- Referrals for emotional and practical support for carers
- Information and advice on issues such as benefits and other help available.
- Helping carers to share experiences through peer group support and social activities.
- Access to volunteering

Carers accessing Social Prescribing were able to access specialist support and

advice from Carers Support and mental health carers were referred to the Mind Carers Peer Support service. Feedback was overwhelmingly positive which was typified with a mental health carer who has been caring for her son for over twenty years and had a significant on her wellbeing:

“I have gained so much support and actually emotional support from the Monday Group. What’s great is that the people have experienced what I have...I now meet with them regularly and we go for coffee,, we listen, we talk....Its helped me it really has!

Peer support is an important form of social support that focuses on individuals providing first-hand knowledge and wisdom to each other from their own practical experiences. Carers stated that accessing peer support not only provides them with useful practical advice but helped emotionally and has helped them to continue in the caring role. This emotional support is extremely important in maintaining a positive well-being by reducing anxiety and stress. .

“We really enjoy the weekly memory café and we can enjoy this together’ It gets us out and it’s a break for me”.

Much research supports this; social contacts within individuals’ social networks could have psychological advantage for individuals by facilitating social functioning (Forrester-Jones & Grant, 1997) and quality of life (Rapley & Beyer, 1996).

Social prescribing offers carer's respite, providing accessible and relevant community programmes that support the loved ones they are caring for. In this way, it can have a positive impact on the carers quality of life and wellbeing:

“You see I get a rest because he goes to Men in Sheds. He is still going. It’s good to have a named person to talk to and she is at the end of a phone call. She knows me now and is on the ball when organizing respite care.”

Carers were able to specialist welfare rights advice services which provide a multitude of support, advice and advocacy services to individuals with multiple and varied needs and eligibility for services and assistance. The impact of additional resources was considerable: increased affordability of necessities (utility bills, food, transport transport); increased capacity to cope with financial emergencies; and reduced stress related to financial worries. The resources enabled social relations, and increased access to services and civic activities.

One of the clients who approached Social Prescribing cares for her husband with dementia, diverticulitis and he also has mobility issues. She was given financial welfare advice as part of social prescribing. The couple have also joined support groups and both reported improvements in confidence and quality of life. The carer is now on the Carers Information and Support Programme (CRISP) course for dementia, and also received a blue badge through Carer’s Support. This has allowed her to access community services such as the memory café.

“We have received great support.... We’ve had some advice on things we can claim and I now have a Blue Badge which has enabled us to get out more. The memory café has been a blessing as well. We met others which had been a fantastic lift to us both.”

Additional benefits

One of the benefits of the social prescribing service in Bexley is that the coordinator often suggests volunteering opportunities to those who have expressed an interest in doing this. There have been nine referrals to volunteering programmes including Age UK, Evergreen Care Bexley, Mind and Bexley Voluntary Service Council. Participants reported that volunteering has helped including reduce social isolation, and increased employability and skills,

“I think I’ll get more out of it and I will be able to give something back which would be good”

“Oh yes I think getting involved has had quite a positive impact on my wellbeing.”

Social prescribing web tool

As part of the social prescribing pilot in Bexley, a web tool was developed by the CCG to monitor referrals and to provide an online platform for the pilot. This enables the providers to be able to communicate with the coordinator and the ability to review the details of the consultation, and wellbeing questions. The web tool is confidential and secure, with all clients having a unique client number.

Feedback from the voluntary sector highlights several limitations with the current version of the web tool, including limited reporting capabilities and difficulties tracking specific outcomes. It is also not currently possible for the coordinator to communicate directly with providers through the tool, although the providers can communicate with the coordinator.

Social prescribing referral providers and services

The social prescribing pilot was perceived positively by many of the voluntary and community service organisations in Bexley and all were keen for the scheme to continue.

“We have benefited from the referrals especially for the welfare benefits service and day care. I would be happy for this service to continue and have enjoyed working with the staff in other agencies and at Mind and think the concept of it is extremely appropriate and important for the Borough.’ Age UK, Bexley”

The pilot also highlighted a number of challenges related to voluntary and community services and providers. Extending the age eligibility criteria to include individuals aged 18 years and over presented a challenge for the programme. This is because it was originally set up to support the older generation and their carers. Much was undertaken to extend the referral options so the coordinator was able to signpost these individuals to appropriate voluntary and community support organisations.

Another challenge was that some of the activities and services had long waiting lists or a lack of availability. For example, a number of clients wanted gardening support but this was not available at the start of the pilot. There was also a 6-8 month waiting list for befrienders.

Summary and conclusions

Social prescribing is becoming increasingly recognised as an important means of harnessing the resources of the voluntary and community sector to improve the health and wellbeing of the public. It features in current NHS and local directives that supports its integration across the wider health and care system, giving GPs a model to provide community based support for their patients (NHS, 2016; Primary Care Foundation and NHS Alliance, 2015). It also provides an option to help balance the health economy by providing improved community based integrated care, supporting clients to manage their own health (Bexley CCG, 2016).

The findings from this pilot evaluation suggest that social prescribing could reduce the burden on the healthcare system:

- Data from this pilot suggest that social prescribing has a positive impact by decreasing A&E attendances (by 43%) and cost of attendance by £30.35 per client. I
- Findings also suggest that social prescribing could reduce the number of non-elective hospital admissions (by 60%) and consequently, the total cost of non-elective admissions to the NHS. It may also help to reduce average length of stay in hospital (by an average of 7 days per patient).
- Data suggests that social prescribing may have a positive impact on the London Ambulance Service; calls reduced by 56% following the pilot.
- Data for this evaluation are limited in terms of the impact of social prescribing on GP surgeries. Whilst attendance at GP surgeries increased after social prescribing, most surgeries were not able to differentiate between appointments to see GPs, nurses or HCAs. The limited data from one surgery in the pilot area suggested a reduction of GP and nurse appointments, and an increase in appointments to see a HCA. Further data is required to identify meaningful impact of social prescribing on GP surgeries.
- Qualitative data in the pilot suggest that social prescribing has had a beneficial effect on quality of life, wellbeing and social capital for individuals and carers.

The data from the pilot in Bexley suggest that social prescribing is having a positive impact; not only by reducing the burden on healthcare provision and delivering cost savings, but also to the quality of life, wellness and community cohesion to the benefit of residents and the wider community in Bexley. Social prescribing can provide a means to support the complex and multifaceted needs of residents, particularly those within the elderly population who may be socially isolated, living alone at the onset of dementia or by providing support and social connection to those caring for loved ones. By being part of the tapestry of an integrated pathway of healthcare, it provides a means of supporting an aging population in Bexley where the services offered by the voluntary and community sector relieve some burden on primary care.

Limitations of the evaluation

It is important to consider these findings in the context of the limitations of the evaluation.

These findings are based on a small number of social prescribing clients (n=81). As such, whilst these results can give an illustration of the possible impact of social prescribing in Bexley, they must be considered in the context of this small sample. As such, these findings may not be illustrative of the final social prescribing model in Bexley.

The data on the impact of social prescribing on GP surgeries is also limited. Surgeries were not able to break down the information by GP, nurse or HCA for the majority of surgeries. As such, it is difficult to ascertain the impact of social prescribing on this primary care service. Buy in to the social prescribing pilot was mixed across the GP surgeries across the Clocktower area; with some GPs referring far more patients than others.

The social prescribing web tool was difficult to use and this difficulty increased the more clients that were signed up to the pilot scheme.

Provider information on the web tool was limited and often client's files were not updated. Therefore it was difficult to ascertain what action plans were followed through. This was further complicated by the lack of memory of the aging sample of this evaluation when the coordinator interviewed the clients on review for the purposes of this evaluation.

Recommendations

- Social prescribing should be developed to become fully integrated as a patient pathway for primary care practices throughout LB Bexley and to strengthen considerably the links between primary health care providers and community, voluntary and local authority services that influence the wider determinants of mental health, for example leisure, welfare, education, culture, employment, and the natural environment.
- Integration with Primary Care is vital to the success of the service. The main referral route should continue to be GPs, and Social Prescribing staff should also be based within GP surgeries during a weekly timeslot
- Volunteers (Health Champions) can add value to promote the scheme and need to be well trained and supported and valued.
- Some GPs and Practice Managers are able to support the service and refer more patients than others. They can be utilised as champions of the service to encourage others to refer.
- Referrals mechanisms should be reviewed and if possible simplified for GPs and practice staff to use, and tailored flexibly to suit individual surgery systems as needed.
- Providing regular feedback about outcomes for patients encourages a higher number of referrals from GPs as well as ensuring greater appropriateness of referrals. The service

should provide regular reports for each surgery showing reasons for referral and services referred to.

- On the basis of the consultation undertaken, it is clear that the Social Prescribing project adopted an inclusive and strategic approach to developing the project. However the communication between some agencies could have been improved. A number of partners were unsure of the remits particularly as they did not receive funding.
- Project works closely with the Bexley Mayors campaign to end loneliness in the LB Bexley and this should be imbedded in the future of social prescribing.
- More work should be done to access people with learning difficulties so that they can engage with the scheme.
- The data system needs urgent reviewing as it currently is unable to generate any detailed reports. A more user friendly system would benefit with provider updates.
- Patient outcomes have been measured using a variety of methods throughout the pilot, including patient follow-up interviews. As the landscape of health services shifts, new models of outcomes measuring need to be identified and implemented

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